Michigan Mental Health Commission

established by Governor Jennifer Granholm's Executive Order 2003–24

MEETING SUMMARY

February 2, 2004
Boji Tower, Senate Hearing Room
Lansing, Michigan

Commissioners Present

C. Patrick Babcock, Chair and Waltraud Prechter, Vice-Chair; William Allen, Fran Amos, Elizabeth Bauer, Thomas Carli, Patricia Caruso, Nick Ciaramitaro, Bill Gill, Beverly Hammerstrom, Rick Haverkate, Gilda Jacobs, Joan Jackson Johnson, Alexis Kaczynski, Guadalupe Lara, Sander Levin, Kathryn Lynnes, Milton Mack Jr., Samir Mashni, Andy Meisner, Janet Olszewski, Donna Orrin, Jeff Patton, Brian Peppler, Michele Reid, Mark Reinstein, Roberta Sanders, David Sprey, Sara Stech, Rajiv Tandon, Maxine Thome, Marianne Udow, Thomas Watkins

The meeting was convened at 8:00 AM.

Welcome and Certification of Commissioners

Governor Granholm welcomed the commission members and thanked them for their participation in addressing this important issue. She then certified the commissioners by having them recite the oath of office of Mental Health Commissioner.

Convening and Introductions

Patrick Babcock, Director of Public Policy for the W. K. Kellogg Foundation, called the meeting to order, introducing both himself and Vice Chair Wally Prechter, President of the Heinz C. Prechter Fund for Manic Depression.

The following are highlights of the comments made as the rest of the commissioners introduced themselves and described what they believe it would mean for the commission to be successful.

Commission Teamwork

- I'm looking forward to working with the best minds in the state.
- I would like for all of us to work together as a team.
- My hope is that we can harness the collective wisdom around this room.
- We need to come with an open mind.
- We need to ask tough questions and not worry about turf.
- We have to respect each other's diverse styles and remember who the real customers of our work are.

Create a System Centered on Those Served

- We should design a system that treats all people with dignity.
- I'm interested in making sure that the improvements will serve consumers first.

- We need to make sure that consumers are leading the system, not vice versa.
- If the system isn't good enough for the people we love, it's not good enough.
- Put consumers first.
- We need a system of services that is acceptable to consumers.
- We need to look at the system from the point of view of individuals and families served by the system.
- Success would be an improvement in the quality of life for adults with serious mental illness and children with serious emotional disorders.
- We would create a patient-centered system according to best practices using research.

Improve Service Delivery and Access

- Partnerships are key.
- Address coordination with public partners. We need to work together with our partners to create an improved system.
- We should eliminate or reduce the need for local and state corrections to house the mentally ill.
- I am committed to increasing access and reducing stigma.
- There would be easy access to a user-friendly system.
- We would reduce disparities for racial and ethnic minorities.
- There would be fewer problems with access.

Children's Mental Health

- Children and families should be looked at separately from adults in the system.
- I'm particularly interested in increasing access for children and adolescents.

Funding

- I hope the commission will look at overlap for administrative costs.
- We need a cost-effective, therapeutically effective system without putting a strain on the public financial base.

Broad, Systemic Change

- I hope we design a system that is simple.
- We should utilize the spotlight to make necessary political and systemic changes.
- We need a system of services that is lean in terms of structure.
- We should develop a blueprint for a strong modern mental health system. We should determine what we need to do to make our system the best in the country.
- I am hoping to come out with positive recommendations to change the system.
- We need to look at ways of redesigning funding to break down silos to improve access.

Donation of Funds by the Flinn Foundation

Executive Order No. 2003-24 establishing the Mental Health Commission states, "The commission may accept donations of labor, services, or other things of value from any public or private agency or person." Leonard Smith of the Ethel and James Flinn Family Foundation addressed the commission, saying that the foundation has offered to fund the staffing of the commission by contracting with Public Sector Consultants Inc. Fran Amos submitted a motion to accept the contract and Jeff Patton seconded the motion, which was approved with a unanimous vote.

Overview of Agenda, Commission Charge, and Work Process

After reviewing the agenda for the day's meeting, Pat Babcock and Wally Prechter reviewed the charge to the commission as summarized from the executive order: Identify and assess pressing issues and challenges and make recommendations to improve the public mental health system.

The chair and vice chair then reviewed the work plan and meeting schedule for the commission; the roles and responsibilities for each party involved in the commission; and protocols for meetings, reaching consensus, public comment, and communication. All of these materials are located in the commissioners' binders and will be posted on the commission website, *www.michigan.gov/mentalhealth.*

Commissioner Dialogue on the Work Process

After the review of the materials listed above, the commissioners were offered the opportunity to respond and offer feedback. A synopsis of that discussion is provided below.

Reaching Consensus

With regard to the protocol for reaching consensus, commissioners asked about the rationale for not allowing minority reports with the commission's final report. Pat Babcock responded that minority reports may weaken the final recommendations. Others commented that while they agree the commission should try to reach consensus, room should be made in the final report for noting commission members' reservations on specific recommendations. Pat Babcock suggested that if there is general agreement with this approach it could be used as a "last ditch effort" after all possibilities for reaching consensus have been exhausted

How Do We Address the Developmentally Disabled?

The commission members discussed the extent to which persons with developmental disabilities (DD) should be included in their deliberations. Some members stated that the DD population is provided treatment under the aegis of the public mental health system and should therefore be included equally with persons with mental illness in the deliberations and the final report of the commission. Others stated that the DD population should be generally left out of the work of the commission, as the executive order specifically names the mentally ill as the population to address.

The commissioners ultimately agreed that the focus of their work should be on the mentally ill and that it should be noted as such in the final report. However, they also

recognized that they are not conducting this work in a vacuum and the DD population has a significant effect on the current structure of the public mental health system. They noted that in the current system structure, "silos" of funding and services exist for the developmentally disabled and the mentally ill. Thus, they agreed that the final report should indicate that the "silos" of developmental disability and mental illness are detrimental to the overall functioning of the public mental health system and should be addressed in the future. The commissioners also felt they should address system flaws that prevent individuals from receiving proper care when mental illness and developmental disabilities co-occur.

Service Delivery and Access

The commission members discussed their charge to assess how mental health services are delivered. They agreed that identifying improvements to service delivery and access will be important components of their work. The commissioners noted that cultural competence and economic barriers should be addressed to improve service delivery and access.

General Discussion

Members of the group expressed their hope that the final recommendations of the commission would be in the form of an action plan that would reflect policy and move the state toward a five- to ten-year–goal for improved system design. The group agreed that the final action plan should be well defined and achievable.

Pat Babcock reviewed the communication protocol for the commission, stressing that members are free to speak to the press on their own behalf, but that they should refrain from speaking on behalf of the commission. The chair and vice-chair will be spokespeople for the commission.

It was noted that although the charge of the commission is to make recommendations to improve the *public* mental health system, the *private* sector intersects greatly with the system, especially with regard to private insurance.

Briefing on the Michigan Mental Health System

Patrick Barrie of the Michigan Department of Community Health (MDCH) provided an overview of the Michigan mental health system, including a historical and policy context and a picture of the current mental health system.

Ken Longton (MDCH) presented the census in current state-owned mental health facilities. He said that approximately 1,100 people are served by state-operated hospitals and centers and approximately 3,000 people are served by prison-based mental health services.

Ken also noted a dramatic increase in co-morbidity in recent years. He reported that the new forensic center is opening this year. When persons have been charged with a crime and are deemed incompetent to stand trial, the forensic center helps determine where they should be held and treated. Both people who are found not guilty by reason of insanity (NGRI) and those who are deemed incompetent to stand trial are treated by the forensic center and through referrals from the center.

Irene Kazieczko (MDCH) reviewed community mental health service programs (CMHSPs), including contracting and funding processes.

Judy Webb (MDCH) gave an overview of the data that is collected by MDCH and discussed monitoring of CMHSPs and prepaid inpatient health plans (PIHPs). Judy stated that the mental health block grant requires data collection at the aggregate level and annual consumer satisfaction surveys. She said there are currently three mandates driving data collection activities. Approximately 31 characteristics are collected on each person served by the public mental health system. Judy also noted that four staff conduct on-site monitoring for both CMHSPs and PIHPs.

These presentations can be found on the commission website, *www.michigan.gov/ mental health*.

Dialogue on the Mental Health System Briefing

Questions, answers, and comments made by commissioners related to the briefing on Michigan's mental health system follow.

Q. Is there a way for states to get out of the IMD exclusion? [The federal Medicaid statute specifically excludes federal payment for services provided to otherwise-qualified individuals, 22 to 64 years of age, in institutions for mental diseases (IMDs). The term "institution for mental diseases" was statutorily defined in 1988 as a "hospital, nursing facility, or other institution of more than sixteen beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.]

A. Patrick Barrie—One state was able to use its 1115 waiver to remove the IMD exclusion. Michigan has never tried to waive that exclusion.

Q. Is there a structure that is Medicaid eligible that can provide medium- or long-term care?

A. Patrick Barrie—No. Unless it's part of a hospital that has fewer than 16 beds. We can provide the commission with an analysis of the IMD exclusion.

Q. When was the state constitution amended to include language about providing services to people with severe mental illness?

A. Patrick Barrie—1963.

Q. How many of those served by the system are Medicaid eligible?

A. Patrick Barrie—Approximately 90 percent of the DD population and 60 percent of adults with serious mental illness.

Q. Can you give us a sense about what levels of noncompliance with a contract it takes to stop funding a contract with a CMHSP?

A. Irene Kazieczko—It is limited to if they fail to meet certain certification requirements. If they don't meet these requirements they get an administrative procedures hearing, and sanctions increase from there. However, if there is a concern for the immediate health and

safety of patients, MDCH has the authority to make immediate changes. We have a division for contract management. The majority of quality management is done through the Division of Quality Management and Planning.

Q. How are mental hospitals and centers staffed?

A. Ken Longton—Staffing is determined by the Staff Need Assessment Program (SNAP). SNAP was last completed in late 2002. Another SNAP will be completed this March. We can provide the commission with reports from both of these assessments.

Q. What percentage of people in state facilities came through the criminal justice system?

A. MDCH—We will find that information for the commission.

One commissioner noted a consequence of the Mental Health Code that makes it difficult to divert people with mental illness from jail or to provide them with treatment when they are released from jail. The code provision regarding the "county of responsibility" requires an individual's county of residence to pay for that person's treatment.

The commissioners requested that MDCH provide them with a breakdown of people served by diagnosis and a breakdown of the prevalence of those diagnoses in the general population.

The department offered to provide any data that the commission requests.

Results of the Commission Member Survey

Suzanne Miel-Uken described the survey and explained that the results were used to propose guiding principles and a framework for the commission's deliberation.

Amanda Menzies highlighted the results of the commission survey. A summary of the survey results is located in the commissioners' binders and can be found on the website.

Proposed Guiding Principles and Framework

Chair Patrick Babcock explained to the commissioners that they would be breaking into small groups to discuss the proposed guiding principles and framework for deliberations. The project management team developed the proposed principles and framework using the executive order and the results of the survey of commissioners.

Small Group Dialogue and Report Out

Commissioners were asked to report back to the entire group with one recommended change to the principles and one change to the framework. Recorders documented all dialogue in the small groups for refining the proposed principles and framework.

Group 1:

For principle 6, this group recommends including references to effective and early intervention and to include supporting the use of a natural support system.

For bullet three of the framework, the group suggested adding "statutory framework" to Organization and Structure.

Group 2:

This group suggested making each principle a concise statement and then including a short paragraph to explain it further.

The group also suggested that the final plan of the commission be a specific action plan with assigned responsibilities.

Group 3:

For principle 1, this group commented that it seems impossible that each recommendation will be acceptable to everyone. They suggested rewording it to read: "Consider the perspective of consumers."

Regarding the framework, the group said it didn't feel like the right way to organize tasks. They believed that all four pieces of the proposed framework should be considered by each work group. They suggested that work groups could be based on items 2a–2e in the staff summary of the executive order.

Group 4:

This group suggested using the term "person" rather than patient or consumer. They also suggested an additional principle that states that recommendations should be able to be monitored.

This group liked the proposed framework and they suggested that a consumer be involved in each of the work groups.

Group 5:

This group suggested the following list of principles:

- Reflect a consensus among consumers, etc. so everyone can participate in the implementation of the recommendations
- Improve the quality of life of people with mental illness and their families
- Promote recovery and advance mental health
- Assure cost-effective and flexible use of resources
- Take into consideration the unique needs of children with serious emotional disorders

This group did not agree with the concept of using the proposed framework as work groups.

Group 6:

This group suggested providing definitions for terms that are used in the principles (e.g., "person-centered")

The group suggested adding "rights protections" to the framework.

Full-group Dialogue on Principles and Framework

After each group reported out its recommendations for changes to be made to the Principles and Framework, the full commission entered into a discussion about how best to organize their deliberations into work groups or subcommittees.

One commissioner said that the commission should plan to design an ideal system, identifying resources that are available right now to move the state toward that goal, and identifying resources that are needed to continue to move the state forward. The commissioner suggested determining goals for this system and setting up a structure for deliberations that feeds into those goals.

Another commissioner supported this, stating that the commission should identify the fundamental elements desired in a system and base the work groups on those elements.

Some commissioners advocated using the framework proposed by the project management team, while several others suggested breaking into groups organized by items 2a–2e in the summarized executive order, which they felt would help them to closely align their work with their charge. Most of the commissioners appeared to agree with this approach.

One commissioner stated that the intersection between the mental health system and the criminal justice system needs to be addressed in the deliberations, however they are organized.

Some commissioners felt that more data would help inform their work. There were requests for more specific data regarding who is being served by the public mental health system, what the objectives of service providers are, and how services are provided. This information should be compared to data showing the needs of the general public so the commissioners can identify where gaps in services exist.

Another commissioner noted that, in addition to the public dollars being spent to fund the mental health system, there are volunteer organizations funded by private dollars that also serve the mentally ill. Those organizations serve as a safety net. The commissioner asked who uses these volunteer services and why they are not able to receive the services they need from the public system.

The commissioners also requested information about waivers pertinent to the mental health system (including an explanation of the Medicaid Adult Benefits Waiver that was just approved) and a list of state mental health services and alternative services.

The Michigan Department of Community Health again offered to provide whatever data the commission needs to inform its deliberations. Data and reports will be made available on the website.

Patrick Babcock said that the project management team will take everything that was discussed today to rewrite the Principles and suggest a new way to organize the commission's work groups.

The commission agreed to postpone discussion of the public hearings until the March 1 meeting.

Planning for the Next Meeting

The commissioners agreed that the March 1 meeting should be held at the same location as this meeting (Boji Tower Senate Hearing Room).

One commissioner suggested that the public hearings could be used as an opportunity to educate people about mental health/illness. He requested that commission staff put together an information packet.

Public Comment

The public comment will be summarized by the Michigan Department of Community Health for commission review and consideration.

Adjournment

The meeting adjourned at 4:00 PM.